California MEDICINE

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EDITORIAL

Communications

"COMMUNICATIONS" has become almost a magic word in business, professional and governmental circles in recent years. It has superseded earlier efforts at symbolizing the conveyance of information, attitude or program from one source to another.

In medical circles the term "public relations" was long employed. This was succinctly defined as doing or being good and then telling about it. Examples such as the elder Rockefeller distributing shiny dimes, or the elder Carnegie supplying funds for the construction of libraries bearing his name, were used as epitomizing "public relations." In both examples the subject was recalled as one who had made tremendous profits at public expense and then devoted his efforts to distributing his accumulation for the public good.

Out of this procedure the subject was referred to as "improving his public image." This phrase was Madison Avenue trade talk for creating a favorable atmosphere publicly in the hope that current goodness would counteract earlier public condemnation.

The medical profession, once highly revered and honored, found itself a quarter century ago placed in a defensive position by politicians bent on improving their own public images by distributing goodies to the people. In this instance, however, their benefits were not shiny dimes or new libraries purchased from their own pockets but services performed by physicians. The difference is noteworthy.

Placed in this defensive position, the medical profession turned to Madison Avenue and its equivalents in other cities, asking for help. From this opening request, the word "communications" and all that goes with it have come into being.

If we trace the history of the California Medical Association we find that the physicians in our state realized early in the depression days that they were about to be gobbled up by political demands that their services be dispensed under the control of the state. The physicians themselves would, under such a plan, have become pawns in the hands of the politicians.

This was a direct political move. The answer was to engage in counter political moves and out of this was born the Public Health League of California.

The demand for state compulsory health insurance was repeated in 1945, in 1947 and in 1949 in California. In our national capitol, a strong move in this direction developed in 1948. These were all in the form of specific legislative bills. Each demanded crash action and each was successfully opposed. Even so, the opposition offered was distasteful to many physicians and a demand was developed for a more subtle form of opposition under the direct control of physicians rather than gray flannel suited promoters.

Today the medical profession has become accustomed to the assumption of the care of certain segments of the population by various government agencies. In the state of California alone, 21 medical or health care programs are in operation by ten agencies of state. Government, at county, state and national levels, is in the business of providing health care for one group or another of the people. The aggregate encroachment on the private practice of medicine has assumed large proportions, even though each specific program may be miniscule by itself.

The insurance industry is another third party playing a prominent part in medical practice today. The Blue plans, Shield and Cross, are another entity.

While the profession has accepted these programs, albeit grudgingly, physicians have tended to establish their own philosophies and standards as to how each plan should be handled. Ask a question on the philosophy of dealing with one program in a group of ten physicians and you are likely to get ten answers.

Medical organizations, which carry the prestige and authority to deal effectively with various plan promoters, are now placed in the position of seeing their membership divided and their own authority curtailed in proportion to the variance in opinion. A single question a few years back—should physicians receive vendor payments from the state or should payment be made to the patient and he be given the responsibility of paying the doctor?—drew vociferous opinions for patient responsibility but an overwhelming vote for vendor payment.

These considerations bring into sharp focus the vital need for communications. Decisions must be made at top level and then communicated to the membership. The members, in turn, must have available means for expressing their wishes. When members' wishes can be crystallized into an established method of procedure, the organizational officials are in a position to act.

The California Medical Association has adopted this concept of "communications." In brief, the word connotes a two-way street for the interchange of ideas, suggestions, plans, programs. Simultaneously, the same avenues of information must be kept open between officials and staff, between the state and the component societies, between committees and officials.

With such lines of communication open, the medical profession will be enabled to match the old public relations formula of being or doing good and telling about it.

The California Medical Association has now established its informational organization in a Bureau on Communications. The bureau is geared to prompt, proper and adequate procedures in assuring all interested parties of giving all others the opportunity to learn what is going on and why. The association has not attempted to hire outside professional firms, counting on them to transform the "image" of physicians into people on pedestals. Instead, it is establishing its own internal affairs and procedures into something alive, vibrant and workable.

The concept is new, the opportunities vast and the prognosis excellent.